Healthy neonate born at JDJ hospital after serious birth complication. Photo credit: IRC

Key Findings:

- **Advocacy efforts led MOHSW to endorse community based family planning**
- **Adolescent sexual and reproductive health programs are needed to address concerns of adolescents**
- **Limited HR capacity particularly in the area of management and supervision at health facilities. More training is needed.**

PROGRAM LEARNING BRIEF

BETTER FUTURE, BETTER LIVES: REDUCING CHILD AND MATERNAL MORTALITY IN LIBERIA

At a rate of 994 maternal deaths per 100,000 live births, Liberia has one of the highest maternal mortality ratios (MMR) in the world. Child mortality in Liberia is also one of the highest in the world with 110 under-five deaths, 32 neonatal deaths and 71 infant deaths per 1000 live births. The Government of Liberia has recognized the critical role of family planning (FP) in preventing and reducing maternal and child mortality rates. The IRC will work with the Ministry of Health and Social Welfare (MoHSW) to implement innovative interventions in a rural/urban environment to strengthen the integration of Maternal Neonatal Child Heath (MNCH) services and increase the awareness, availability and acceptability of quality FP services to reduce maternal and child mortality in Liberia. Through this project, the IRC will also provide evidence to inform policy and practice on integrating FP in various MNCH platforms in Liberia.

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

November 2013

Background

The IRC is working with the MoHSW, the Planned Parenthood Association of Liberia (PPAL), and Columbia University to implement and test interventions that increase awareness, availability, accessibility, and quality of integrated Maternal, Neonatal and Child Health (MNCH) programs, Immunization and FP services at the community and health facility level.

High rates of unintended pregnancies contribute to Liberia's MMR, with five percent of maternal deaths being due to unsafe abortion. Research indicates that short birth spacing is associated not only with elevated risk of maternal death, but also increased neonatal, infant and under-five mortality, and child malnutrition. FP is an effective strategy for addressing these public health issues. Liberia's current contraceptive prevalence rate is 11% and the unmet need for family planning is 36%. The IRC and its partners will collaborate with the MoHSW to save the lives of women and children by increasing demand for, access to, and uptake of high-quality FP services.

Project Design

The project will target three hospitals in Montserrado and Lofa Counties and five primary health care (PHC) facilities and five schools in rural Lofa, which together have an estimated catchment population of 504,863, with 100,973 children under-five and 111,070 women of reproductive age (15-49 years).

The project will be implemented in MoHSW supported communities and facilities in rural Lofa and urban Montserrado Counties to increase FP integration into the larger MNCH health package. The project strategy includes integrating community-based family planning (CBFP), including injectable contraception, into the service package of Community Health Volunteers (CHVs) who currently deliver maternal, newborn and child health interventions in a house-to-house model; introducing FP into MoHSW/Ministry of Education school

health programs; and integrating FP services into the provision of routine MNCH health services, including Extended Program of Immunization (EPI) as well as antenatal (FP counseling), labor and delivery, and post-partum care while task shifting the delivery of these services to lower cadre health staff in these sections.

Methodology

The project uses multiple methods to monitor and evaluate its findings. These include use of routine program monitoring using the MOHSW Health Management Information System (HMIS), Logistic Management Information System (LMIS) and project reports for five health facilities, three hospitals and five schools. A baseline survey has been conducted in targeted communities, and preliminary results from the Knowledge, Practice and Coverage (KPC) survey illustrate that there is a relatively high knowledge of FP (51%); CHVs are competent and proficient in administering Depo Provera (DMPA) injectable contraceptives and taking on new tasks as illustrated by the >90% success rate in the DMPA training; and health facility staff are knowledgeable and capable of taking on new tasks, such as strengthening EPI and Post Partum Family Planning (PPFP) at the health facilities. Over 12,000 couple's year protection (CYP) (including condoms, pills, inserts and injectables) was provided in the first year of the project in Lofa and Montserrado.

Findings

Preliminary findings for the school health component reveal that adolescents are a high risk group for risky sexual behavior and pregnancy, as is evidenced by the high sexuality rates (73%) in adolescents reported by the KPC survey. In March 2013, PPAL conducted a focus group discussion with students and peer educators to gather opinions on sexual and reproductive health (SRH) and the program. The adolescents that took part all discussed the importance and relevance of the *'Better Futures, Better Lives'* program. A few common themes arose: students lacked knowledge and information on SRH; students felt health facilities were not youth friendly; and there were often stock outs of commodities at the facilities, which was a key deterrent in accessing services. Adolescents noted that the establishment of parent teacher associations at each school strengthened support for the program.

Continued advocacy efforts played an important role throughout year one of implementation. Advocacy efforts included participation in the reproductive health technical committee, participation in the review process of the Accelerated Action Plan for reducing maternal mortality and dissemination of the program results. Community based family planning has been endorsed by the MoHSW as one of the strategies to expand FP services and consequently contribute to reduction of maternal and child mortality.

The IRC conducted an assessment at three hospitals to find out if the Intrauterine Contraceptive Device (IUCD) is acceptable by health workers and patients and to identify key myths and/or misinformation that the project will need to address. In total, 93 IUCDs were inserted over the period, 30% of which were inserted within 24 hours of delivery/abortion. While the MoHSW health staff (nurses, physician assistants, certified midwives, doctors) were successfully trained and coached by the IRC doctors, the project found that behavior change strategies will be needed to counter the myths regarding IUCD at the health facilities.

Stock outs remain a critical challenge to the success of this program, particularly for RH commodities; There were frequent stock outs throughout year one implementation. The project findings during the first year of implementation revealed that while demand has been created for FP commodities, limited stocks were not able to meet the increased demand. Focusing on the supply chain and ensuring availability of supplies (RH commodities, vaccines and antigens, medical supplies) will be a key priority in year two.

Conclusions and Lessons Learned

Conclusions and lessons learned from the first year of project implementation include:

Continuous advocacy and coordination, integral to the success and sustainability of the program, and advocacy at both the central and county/district level is needed continuously. Coordination between stakeholders and partners regarding progress of the program will demonstrate a positive impact and provide further advocacy opportunities, particularly in order to influence policy change and program design.

Supply chain – a weak supply chain for RH commodities at both the facility and community level lead to under-stocking and stock-outs which necessitated frequent emergency requisitions

Limited human resource capacity – Human resources at the health facilities and district levels, particularly for supervision of CHVs, is constrained. The Community Health Services Supervisory strategy outlined in the MoHSW Community Health Services Policy has not yet been financed and implemented. Additionally, health facility staff need additional information on PPFP to ensure all methods can be promoted at the facilities. Limited training in IUCD insertion also posed challenges.

Adolescence girls are a particularly high risk group that should be specifically targeted by the program and other RH interventions in the area.

CBFP is a very effective way of increasing CYP through improving access to FP services. The trained CHVs have been able to provide such a high number of FP methods beyond the pilot project period.

A standardized incentive package for the CHVs and peer educators on the program would improve performance and streamline activities working with similar cadres of volunteers

Recommendations and Use of Findings

Advocacy and coordination with stakeholders is an integral component to the success of the program. Advocating for policy change on community based family planning program is needed as well as strengthening the RH commodity distribution. The program will continue to disseminate results and findings in all technical meetings and other coordination forums.

Commodity stock outs can be minimized if collaboration between partners and supply chain stakeholders improves (i.e. commodity quantification; regular communication and feedback regarding availability of supplies and so forth). The IRC is a member of the Commodity Security Working Group and has lobbied for extra supplies for the project as well as support the interim top up strategy adopted by USAID and MoHSW.

Supervisors are key persons to involve in CHV trainings as this will facilitate initiation and continuation of supportive supervision during implementation. Additionally, sustainability of this intervention can be ensured if supervisors are trained and engaged, FP champions are identified in health facilities, and other methods for supervision, such as CHV peer supervision are explored.

Standardizing incentive packages for the CHVs from the central level, to avoid challenges among implementing partners collaborating with different cadres of volunteers, is crucial. This issue is currently under discussion at the MoHSW.

IUCDs are not commonly used and health facility staff need continuous training to improve this component of the program. In addition, the program will develop a strong awareness strategy to address myths among the staff on PPIUD and IUD in general.

The '***Better Futures, Better Lives'*** in Lofa and Montserrado County, Liberia is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The *'Better Futures, Better Lives'* project is managed by the International Rescue Committee (IRC) under Cooperative Agreement No. AID-OAA-A-12-00094. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about the Better Futures, Better Lives project, visit: www.theirc.org

PROGRAM LEARNING BRIEF